Form # PCC-1228-FFE
Orig 04/03 Rev 01/18

ACMH

Name: _____

SS#: XXX-XX- _____

Date of Birth: _____

Patient ID

Patient Instructions Regarding PHI for ACMH Clinics

Communication Preferences

To ensure proper and timely handling of your test results which have been ordered by your health provider, please complete the following:

Home Address:	_____ _____ _____
Home Phone#: _____	Cell Phone #: _____
Work Phone #: _____	Alternate #: _____

I authorize my physician, physician group or staff member employed by the practice to release any and all medical test results or other medical information relating to my treatment to: **(initial all choices that apply)**

Patient Initials	MEANS OF COMMUNICATION		
	May leave a message at work to call the physician office.		
	May leave a message on any (home or work) answering machine/voice mail to call the physician/service office.		
	May leave a message on the home answering machine regarding the test result/treatment.		
	May leave a message with a family member for me to call the physician office.		
	May give test results/instructions to:		
	Name of Individual:	Relationship to you:	Phone Number:
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	May only release test results to the patient.		
	Other patient specific communication instruction: May send text message confirming scheduled appointment.		

I understand this information used and these instructions will be in effect unless changed or revoked by me either in writing or by completing a new instruction form.

_____ _____

Date Patient (legal representative) Signature